CENTER OF PSYCHOLOGICAL EFFECTIVENESS
7390 NW Fifth Street, Suite 5, Plantation, FL 33317 * Phone (954) 583-8831

✓ CONSENT TO Allow CYBER COMMUNICATIONS ✓

I________________________ hereby give my permission to the Center of Psychological Effectiveness to release/obtain information of my presence in therapy by e-mail or text. The e-mail or text will be utilized for appointment reminders or to reply to communication which, I, the patient, have initiated. I understand that my records are protected under the Federal Confidentiality regulations (42 CFE Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations**. I AM WAIVING THESE RIGHTS FOR THE ABOVE MENTIONED COMMUNICATIONS.**

I AUTHORIZE THE FOLLOWING CYBER COMMUNICATIONS:

___E-Mail at ____

___Text at ____

I understand that the cyber communications are NOT protected by any firewalls. I am freely waiving my rights for the purposes of my own convenience. I will not hold the Center of Psychological Effectiveness, Inc. or my licensed therapist responsible for any breach of privacy.

Communications by text and e-mail are NON-PROTECTED communications.

This authorization will automatically expire on: ________________________(Cannot exceed one year)

*I may revoke this authorization at any time upon written notice to The Center of Psychological Effectiveness. I acknowledge that such revocation will not be effective if The Center of Psychological Effectiveness has already acted in reliance upon this authorization. A photocopy of this document is to be considered as valid as the original document. Information that is being released under this authorization may be re-disclosed. The privacy of this authorization may not be protected under the federal privacy regulations. I hereby release The Center of Psychological Effectiveness from any liability which may arise as a result of the use of the information released in accordance with this authorization.

____________________________________ ____________________________________
Patient's Signature Date Witness Signature Date